

Behavioral Respite Services Protocol Checklist

Service Recipient's Name _____ Date of Birth _____
(Last, First)

Reviewer's Name _____ Date Request Submitted _____
(Last, First)

Technical Review

<input type="checkbox"/> YES <input type="checkbox"/> NO	<p>Is the correct funding source, site code, and service code used in Section C of the Individual Support Plan?</p> <p>If YES, continue to Question #1.</p> <p>If NO and the wrong funding source, site code and service code is due to a simple error, correct the error and continue to Question #1.</p> <p>If NO based on lack of a site code because the provider is not licensed or does not have an approved provider agreement, deny as non-covered due to failure to meet provider qualifications as specified in the waivers and in the TennCare rules applicable to the waivers.</p>
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A. Behavioral Respite

1. <input type="checkbox"/> YES <input type="checkbox"/> NO	<p>Is there documentation that the service recipient is experiencing a behavioral crisis that necessitates temporary removal from the current residential setting (i.e., family home, Supported Living, Residential Habilitation, Family Model Residential Support, Medical Residential Services, excluding any institutional setting) in order to resolve the behavioral crisis?</p> <p>If YES, proceed to question #2.</p> <p>If NO, deny as a <u>non-covered service</u>.</p> <p><i>In addition</i>, deny as a <u>non-covered service</u> any portion of the requested number of days of Behavioral Respite Services requested which <i>exceeds</i> the waiver service limit of 60 days per service recipient per program year.</p>
2. <input type="checkbox"/> YES <input type="checkbox"/> NO	<p>Medical necessity review questions:</p> <p>a. Is there sufficient information in the Individual Support Plan (ISP) and/or supporting documentation to show that:</p> <p>(1) The service recipient is exhibiting a pattern of aggressive or self-injurious behavior that has resulted in serious injuries (requiring medical treatment) or serious harm to self, housemates, or staff during the past 14 days; AND</p> <p>(2) The number of episodes of aggressive or self-injurious behavior or the intensity of the aggressive or self-injurious behavior by the service recipient toward self, housemates or staff has significantly increased during the past 14 days to the extent that the safety of the service</p>

	<p>recipient, housemates, or staff cannot be assured unless the service recipient is removed from the current residential setting to mitigate the behavioral crisis; AND</p> <p>b. Is there sufficient documentation to conclude that the provision of Behavioral Respite Services can be reasonably expected to resolve the behavioral crisis so that the service recipient can safely return to the residential placement?</p> <p>If YES to both of the criteria specified in “2.a” and “2.b” above, proceed to Question #3.</p> <p>If NO to any criterion specified in “2.a” or “2.b” above, stop and deny as <u>not medically necessary</u>. All of the unmet medical necessity criteria must be specified in the denial letter.</p> <p><i>In addition, deny as a <u>non-covered service</u> any portion of the requested number of days of Behavioral Respite Services requested which <i>exceeds</i> the waiver service limit of 60 days per service recipient per program year.</i></p>
<p>3. <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Is the number of days of Behavioral Respite Services requested <i>consistent with</i> and not <i>in excess of</i> the number of days of Behavioral Respite Services needed to resolve the behavioral crisis and facilitate the service recipient’s safe return to the residential placement?</p> <p>If YES, stop and <u>approve</u> the amount of Behavioral Respite Services requested (subject to the waiver service limit of 60 days per service recipient per program year). <u>Deny as a <u>non-covered service</u></u> any portion of the requested number of days of Behavioral Respite Services requested which <i>exceeds</i> the waiver service limit of 60 days per service recipient per program year.</p> <p>If NO, <u>approve</u> the number of days of Behavioral Respite Services requested that is <i>consistent with</i> the number of days of Behavioral Respite Services needed to resolve the behavioral crisis and facilitate the service recipient’s safe return to the residential placement (subject to the waiver service limit of 60 days per service recipient per program year). <u>Deny as <u>not medically necessary</u></u> that portion of the total number of days of Behavioral Respite Services requested that is <i>in excess of</i> the amount of the number of days of Behavioral Respite Services needed to resolve the behavioral crisis and facilitate the service recipient’s safe return to the residential placement.</p> <p><i>In addition, deny as a <u>non-covered service</u> any portion of the requested number of days of Behavioral Respite Services requested which <i>exceeds</i> the waiver service limit of 60 days per service recipient per program year.</i></p>
<input type="checkbox"/> Approved	
<input type="checkbox"/> Denied	Criteria _____ not met.